SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR FAIR HEARING FOR MEDICAID APPLICANT/BENEFICIARY

PART I -- To be completed by the eligibility worker upon receipt of an oral or written request for a hearing. Completion of this section is required prior to releasing this form to the applicant/beneficiary/authorized representative, or the Division of Appeals

Name of Applicant/Beneficiary:	**Household Number:**	**Payment Category:**
Address of Applicant/Beneficiary:	**Name of Supervisor:**	
Telephone Number of Applicant/Beneficiary:	**Name of Eligibility Worker:**	
Name of Authorized Representative (if applicable):	**Address of Eligibility Worker:**	
Address of Authorized Representative:	**Telephone Number of Eligibility Worker:**	
Specify which category: ☐ ABD ☐ BCCP ☐ FP ☐ HCBS ☐ GH ☐ LIF ☐ NH ☐ OCWI ☐ OSS ☐ PHC ☐ SLMB ☐ TEFRA ☐ WD ☐ Pass-Along ☐ Other:	**Reason(s) for Action Being Appealed:** ☐ Resource ☐ Income ☐ Level of Care ☐ Disability ☐ Other: _____ _____ ***If disability, submit disability decision notification letter***	
Type of Action Being Appealed: ☐ Case Closed ☐ Case Denied ☐ Other Action:		
Date the notice informing the applicant/beneficiary/authorized representative of the action he/she wishes to appeal was sent	**Date the action** is effective (the first date of ineligibility or the date of denial in MEDS)	
Supervisory Review ☐ The case record has been reviewed. All other options have been explored and the action being appealed is appropriate.		
Signature of Supervisor	**Date**	

THE INFORMATION BELOW MUST BE COMPLETED BY THE APPLICANT/BENEFICIARY/AUTHORIZED REPRESENTATIVE

☐ I have provided a signed letter to request an appeal (Complete Part III only if you do not want to continue benefits)
☐ I have not provided a signed letter to request an appeal (Complete Part II and Part III)

PART II -- To Be Completed by the Applicant/Beneficiary/Authorized Representative who did not provide a written request

I request a fair hearing from the Department of Health and Human Services because:

☐ Action has not been taken on my application within a reasonable time.
☐ My application has been turned down.
☐ My service has been stopped.
☐ My service has been reduced or changed.
☐ I have been charged with an overpayment.
☐ Other: *(Explain)* _____

_____

_____

(Attach additional sheets of paper if more space is needed.)

PART III -- To Be Completed by the Applicant/Beneficiary/Authorized Representative

If I am given a fair hearing:

☐ I want at least 30 days advance written notice of my hearing date as offered by State law.
☐ I want my hearing to be held as soon as possible, and I will be satisfied with at least 10 days advance written notice of my hearing date.

I understand that I <u>may</u> be eligible to continue to receive Medicaid benefits until a decision is made regarding my appeal. If I am eligible to receive continued benefits (check one of the following):

☐ I understand that I must repay the benefits I continue to receive if the appeal decision is not in my favor.
☐ I do not wish to receive continued benefits.

Signature of Applicant/Beneficiary/Authorized Representative:	**Date:**

Please return this form to the Medicaid Eligibility Worker shown above. Upon receipt, the eligibility worker will submit your request to the Division of Appeals. You will also receive a copy of the information that was used to make the decision regarding your Medicaid eligibility.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REQUEST FOR FAIR HEARING FOR MEDICAID APPLICANT/BENEFICIARY

INSTRUCTIONS

Part I
This section is completed by the eligibility worker when an oral or written appeal request is received. The eligibility supervisor must review the case decision to determine that all options have been considered and the action was appropriate, and sign and date Part I. After the case is reviewed by the supervisor, the DHHS Form 3260 is sent to the applicant/beneficiary/authorized representative.

Part II
Written Request for an Appeal
If the applicant/beneficiary/authorized representative submits a written request for a fair hearing, the eligibility worker must use DHHS Form 3315, Appeals Checklist, to prepare a summary and supporting documentation for the action that is being appealed. The letter from the applicant/beneficiary/authorized representative is attached to DHHS Form 3260 and submitted with the appeal package to the Division of Appeals within five (5) calendar days of receiving the written request.

A complete copy of the appeal package is sent to the applicant/beneficiary/authorized representative with DHHS Form 3260, and a copy is retained in the file. The applicant/beneficiary/authorized representative is not required to return DHHS Form 3260, but may opt to complete Part III and return the form. If the applicant/beneficiary/authorized representative completes Part III and returns DHHS Form 3260, the worker is not required to forward a copy of this DHHS Form 3260 to the Division of Appeals since the form was submitted with the written request.

Oral Request for an Appeal
If the applicant/beneficiary/authorized representative makes an oral request for an appeal, the eligibility worker must complete Part I of DHHS Form 3260 and send the form to the applicant/beneficiary/authorized representative. The applicant/beneficiary/authorized representative must check the appropriate box and complete Part II and Part III of DHHS Form 3260.

Upon receipt of the completed and signed DHHS Form 3260, the eligibility worker must use DHHS Form 3315, Appeals Checklist, to prepare a summary and supporting documentation for the action that is being appealed. The appeal package, including DHHS Form 3260, is sent to the Division of Appeals within five (5) calendar days of receiving the written request. A complete copy of the appeal package is sent to the applicant/beneficiary/authorized representative and a copy is retained in the file.

Part III
The applicant/beneficiary/authorized representative must check the appropriate box in this section to indicate:
1. Their understanding of the right to an advanced notice of fair hearing
2. Their understanding of the right to continue their benefits during the appeals process

DHHS Form 3260 must be signed by the applicant/beneficiary/authorized representative.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).

أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:

888-549-0280(رقم هاتف الصم والبكم 1-888-842-3620)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).

နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်၊ ကျိာ်အတၱ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် ငှ်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ် ဆိုပါ။